QUESTIONNAIRE

Please answer the following questions, fold, staple, and put in campus mail.

Name: _____ Age: ___(years) Sex: (M) (F)

Campus address: _____ Campus phone _____

Do you smoke? yes ___ no ___ (if yes, proceed)

What do you smoke? cigarettes ___ cigars ___ pipe ___

How long have you been smoking? ___(years)

How old were you when you started smoking? ___(years)

What was the product? cigarettes ___ cigars ___ pipe ___

Do you enjoy smoking? yes ___ no ___

Is your enjoyment associated with any specific activity?

after meals ___ with coffee ___ with drinks ___

others (specify) _____

At what time of day do you smoke most?

morning ___ afternoon ___ noon ___ evening ___

Do you usually inhale the smoke? yes ___ no ___

Have you ever noticed a change in smoke flavor or taste?

yes ___ no ___

Do you ever experience a sense of having smoked too much?

never ___ seldom ___ often ___

How would you describe the sensation of "too much smoking"?

"fatigue" ___ throat "tickle" ___ bitter "aftertaste" ___

others (specify) _____

** FOR CIGARETTE SMOKERS ONLY **

How many cigarettes do you smoke per day? ___ cigarettes

What is the cigarette? _____

Thank you!

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Source: https://www.industrydocuments.ucsf.edu/docs/hlnm0000